Self-directed Behavioural Family Intervention

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Abstract

Behavioural family intervention is effective for the prevention and treatment of a wide range of emotional and behavioural problems in children. There is a growing need to address the accessibility of these services. This paper reviews the literature on self-directed interventions designed to help parents manage difficult child behaviours. Evidence regarding the efficacy of interventions is reviewed, and some of the difficulties associated with self-directed programs are discussed. The Self-directed Triple P Program is highlighted as an example of an efficacious and effective behavioural family intervention fitting into a larger multi-level model of family intervention. The discussion of the efficacy and effectiveness of self-directed interventions has implications for service delivery of parenting programs.
Keywords: self-directed, behavioural family intervention, parenting, children.

Parenting interventions attempt to enhance a parent's understanding of child behaviour management and the quality of the parent-child interactions, with the ultimate goal of optimising the child's developmental course (Cowan, Powell, & Cowan, 1998). When parents are taught to use consistent, moderate, and firm discipline, their children exhibit fewer behaviour problems (Arnold & O'Leary, 1997; Forehand, Wells, & Griest, 1980; Webster-Stratton, Kolpacoff, & Hollinsworth, 1988). Behavioural family interventions (BFI) aim to effect change in children's behaviour and adjustment by modifying aspects of the family environment that maintain and reinforce a child's problem behaviours (Sanders, 1992).

There is substantial evidence that BFI, particularly therapist-directed BFI, produces significant changes in both parents and children immediately following treatment (Forehand, Griest, & Wells, 1979) and there is good maintenance of treatment gains and generalisation of these skills (Dadds, Sanders, & James, 1983; Forehand & Long, 1988). There is also evidence for the generalisation of intervention effects beyond the specific behaviours and settings addressed during treatment (Sanders & Glynn, 1981; Serkettich & Dumas, 1996). Furthermore, BFI has effects ranging beyond improvements in child behaviour. Effects have been shown for decreases in parental depression (Connell, Sanders, & Markie-Dadds, 1997; Forehand et al., 1980), anxiety, and stress (Connell et al., 1997). Finally, in general, parents report high levels of satisfaction with behavioural family interventions and find the programs socially acceptable (Forehand et al., 1980; McMahon & Forehand, 1983; Webster-Stratton, 1989).

While there is significant evidence to support the efficacy of BFI, there are a number of factors that limit its dissemination at a community level. Firstly, very low numbers of parents participate in any form of parent education (Sanders et al., 1999) and there is generally low participation by parents of children who have significant behaviour problems (Zubrick et al., 1995) or whose children are believed to be at greatest risk of developing serious behaviour or emotional problems (Harachi, Catalano, & Hawkins, 1997). In Australia, while approximately 18% of children experience an identifiable mental health problem, only 2% of children receive any form of treatment from specialist mental health practitioners (Zubrick & Silburn, 1994) and only 10% of parents participate in parenting education (Sanders et al., 1999). Secondly, there is a range of psychological and cultural implications to seeking help, with great stigma attached to perceived difficulties with coping (Cunningham, 1996). The logistics of attending sessions, either individual or group, such as work schedules, extracurricular activities, difficulties arranging childcare, travel time, and transport costs may prevent many parents from participating in interventions (Cunningham, 1996; Pavuluri, Luk, & McGee, 1996; Spoth, Redmond,

Hockaday, & Shin, 1996). Finally, families may simply live in areas where there are no services, such as rural and remote regions. For these families, accessing services is very difficult, if not impossible. Indeed, research indicates that children from low-income families or rural/remote areas are less likely to receive psychological interventions (Hunsley, Aubry, & Lee, 1997).

Self-directed Interventions

Self-directed interventions have been proposed as one effective way for addressing some of the limitations and access problems identified for traditional BFI and for increasing the reach of services (Sanders, 2000). Such interventions overcome many of the barriers associated with accessing face-to-face services, as there is lowered stigma and significantly reduced or eliminated cost, transport requirements, and timing difficulties. Families can complete self-directed programs in their own homes, in their own time, and at their own pace. Furthermore, self-administered interventions are often very cost-effective and their use can ease the financial burden of mental health on the community.

Self-administered interventions have also been proposed as forming part of a stepped-care approach, where they are used as the most basic and least intrusive level possible. It may be efficient to screen individuals and on the basis of a number of factors, assign them to either more or less intensive intervention. Clients could be offered a self-directed intervention, followed by more intensive intervention if required, allowing the clinician to build on skills and knowledge which have been acquired through the self-directed intervention (Sanders, Montgomery, & Brechman-Touissant, 2000; Webster-Stratton, 1992).

There is limited research in the family intervention field focusing on self-directed interventions. Self-directed interventions have been used to target both specific problem behaviours, as well as broader behavioural difficulties. For example, self-directed interventions have been successful in improving child compliance (Gmeinder & Kratochwill, 1998; Sloane, Endo, Hawkes, & Jenson, 1990), in reducing child tantrums (Endo, Sloane, Hawkes, McLoughlin, & Jenson, 1991), in reducing child sleep problems (Seymour, Brock, During, & Poole, 1989), providing better outcomes in the treatment of ADHD (Long, Rickert, & Ashcraft, 1993), treating nocturnal enuresis (van Londen, van Londden-Barensten, van Son, & Mulder, 1993), and delaying adolescent smoking onset (Bauman et al., 2001).

The broader self-directed interventions focus on parents developing skills to monitor and remediate ineffective parenting techniques, determine their own goals and performance standards, and identify actions they can take to produce change in their child's behaviour. The work of Webster-Stratton and colleagues demonstrates an approach to examining self-directed programs with parents of young children. For example, Webster-Stratton, Kolpacoff, and Hollinsworth (1988) found that a self-administered video modelling intervention was comparable to a group discussion video modelling intervention. The self-administered approach was found more effective when families accessed two brief consultations with a therapist during the course of the program (Webster-Stratton, 1990), suggesting that therapist involvement is an important element of therapeutic effectiveness.

Self-directed programs have also been found to have comparable effects to therapist directed programs. For example, Nicholson and Sanders (1999) compared therapist directed BFI to a self-directed BFI intervention for parents of 7 to 12-year-old children with significant oppositional or conduct problems. Both intervention conditions led to equivalent improvements, compared to a wait-list control; however, there was more satisfaction with therapy in the therapist directed condition. Similarly, Sanders, Markie-Dadds, Tully, and Bor (2000) conducted a large scale clinical trial of 305 families with a 3-year-old child comparing two therapist-assisted versions of BFI and a self-directed BFI condition. Families completing any version of the program showed significant improvements on a variety of self-report and observational measures compared to a wait-list control group, however, there was more improvement in the therapist directed versions of the program, compared to the self-directed version. At 1-year follow-up

families in the self-directed group continued to show improvements and were more comparable to the other two groups.

The empirical support for brief, self-directed interventions is hampered by methodological limitations. Most include some kind of practitioner support (e.g., Endo, Sloane, Hawkes, & Jenson, 1991; Hansen, Tisdelle, & O'Dell, 1984), small sample sizes (e.g., Connell et al., 1997; Gmeinder & Kratochwill, 1998; Hansen et al., 1984), an absence of control groups (e.g., Hunt & Adams, 1989), an absence of child behaviour outcome measures (Flanagan, Adams, & Forehand, 1979; Hansen et al., 1984), and an absence of independent observations of child and parent behaviours (Connell et al., 1997).

Overall, Elgar and McGrath (2003) in a review of self-administered treatments for children and families concluded that there is some evidence to support the use of self-administered interventions. However, more randomised controlled trials addressing various problem areas, long term effects, populations, and media need to be conducted. The authors emphasised the need to conduct effectiveness trials in naturalistic settings, in order to promote integration of programs into health care settings. Furthermore, they recommended that the role of therapist assistance in self-administered treatments needs to be clarified.

Triple P – Positive Parenting Program

Triple P is an example of an empirically supported BFI (e.g., Sanders, Markie-Dadds et al., 2000), which was developed at the University of Queensland and has a considerable history of research and clinical application. It is a program that emphasises parental self-regulation as a means of achieving long-term change in child behaviour.

Triple P is a multi-level, preventively oriented parenting and family support strategy. It aims to prevent behavioural, emotional and developmental problems in children by enhancing the knowledge, skills, and confidence of parents. Triple P incorporates five levels of intervention on a tiered continuum of strength. Triple P is a behavioural family intervention based on social learning principles aiming to: (a) enhance the knowledge, skills, confidence, self-sufficiency and resourcefulness of parents; (b) promote more nurturing, safe, engaging, non-violent and low conflict environments for children, and; (c) promote children's social, emotional, language, intellectual and behavioural competencies through positive parenting practices (Sanders, 1999). The distinguishing features of Triple P are program sufficiency, flexible tailoring to identified risk and protective factors, varied delivery modalities, wide potential reach, and a multidisciplinary approach.

Self-directed Triple P

There is considerable research evidence for variants of Triple P, and the technological aspects of self-directed intervention have been examined. Specifically, the research has examined the role of therapist involvement in enhancing the efficacy of self-directed behavioural family interventions. Self-directed Triple P with no practitioner support has been found to have comparable effects to therapist directed programs (Nicholson & Sanders, 1999; Sanders, Markie-Dadds et al., 2000), however, in general parents were more satisfied with the intervention when they received practitioner support.

Connell et al. (1997) provided a self-directed BFI intervention to 24 parents of preschoolers in regional areas, which included a parent book and workbook, as well as weekly telephone consultations with a therapist. In addition to providing specific advice and support, the telephone consultations also served to promote responsibility for changing parents' own and their child's behaviour. The self-directed

program was effective in reducing levels of disruptive child behaviour, based on self-report measures and changes were maintained at 4 months follow-up. There were also improvements in mothers' parenting practices at post-intervention and follow-up and there was greater satisfaction and competence in parenting skills and lower levels of dysfunctional parenting practices, compared to a wait-list control. Finally, mothers in the self-directed group also reported lower levels of depression, anxiety and stress following the intervention compared to the control group. This study demonstrated the efficacy of a therapist-assisted self-directed approach, however, it did not provide information about the minimally sufficient level of intervention required for change. It also did not provide information about the importance or otherwise of the telephones consultations with parents.

Markie-Dadds and Sanders (2006b) randomly assigned 63 families to a self-directed BFI or a wait list group. Compared to the wait list group mothers in the self-directed BFI condition reported lower levels of child disruptive behaviour, lower levels of harsh authoritarian discipline and higher levels of satisfaction and parenting efficacy, and these gains were maintained at 6-month follow-up. Similarly, Markie-Dadds and Sanders (2006a) showed a tiered intervention effect in comparing a self-directed intervention to an enhanced version with weekly telephone consultations with a practitioner. At post intervention, children in the enhanced version showed lower levels of problem behaviours compared to the standard program, which in turn showed lower levels of problem behaviour than the wait list group. Similarly, mothers showed higher levels of parenting efficacy, while there were no changes in parental adjustment or relationship conflict. However, the differences between the two intervention groups were not maintained at 6-month follow-up, with the standard group catching up to the enhanced group.

In order to address these limitations, Morawska and Sanders (2006b) compared a self-directed BFI (SD-BFI) for parents of toddlers, to a telephone-assisted self-directed (TASD-BFI) version and a wait-list control. There were significant short- and long-term effects of the self-directed intervention in terms of child behaviour problems and maternal parenting style, confidence and anger. However, while participants in the SD-BFI condition made similar statistical gains to the TASD-BFI condition, the TASD-BFI conditions led to clearly superior outcomes in clinical terms. Participants in the TASD-BFI condition changed more reliably and there was a significant shift away from the clinical range for this group. While participants in the SD-BFI also made some gains, these were not as clinically meaningful as those in the TASD-BFI condition. These effects were maintained over a period of six-months. Finally, parents in the TASD-BFI group were more satisfied with the program than those in the SD-BFI condition.

A unique aspect of this study was that using a stringent methodological approach, it demonstrated that self-administered interventions can provide significant benefits in terms of child behaviour and parenting confidence and skills. Furthermore, it was also demonstrated that a tiered effect was evident, where parents who received a small amount of clinical input were able to make more significant, clinically meaningful improvements. It is important to note that the clinician input in this study was relatively minimal. Telephone consultations lasted an average of approximately 10 minutes, and overall on average each participant in the TASD-BFI received just over an hour of clinical input over the course of the program. What makes this hour unique, is that it is designed to enhance parents' self-regulatory skills – that is, enable them to make their own changes and be able to generalise these changes over time and situations. Parents set the agenda for these sessions and they are guided to solve their difficulties or concerns using the resources that have been provided to them, rather than the clinician providing advice or solutions.

The combined results of these studies provide strong support for the use of telephone assisted self-directed versions of Triple P as a low cost, clinically effective intervention for children of all ages. The self-directed Triple P interventions led to results that were not only statistically significant, but also clinically meaningful. These effects were evident particularly for the telephone-assisted versions of the program. The studies provide a strong evidence base for self-directed interventions, which form an

effective part of a behavioural family intervention suite that allows tailoring of strength of intervention to individual problems and families. Furthermore, there is clear evidence for the important role of therapist involvement and support.

Sanders, Markie-Dadds, Tully, and Bor (2000) conducted a large scale clinical trial of 305 families with a 3-year-old child comparing two therapist-assisted versions of BFI and a self-directed BFI condition. Families completing any version of the program showed significant improvements on a variety of self-report and observational measures compared to a wait-list control group, however, there was more improvement in the therapist directed versions of the program, compared to the self-directed version. At 1-year follow-up families in the self-directed group continued to show improvements and were more comparable to the other two groups, and these results were maintained at 3-year follow-up (Sanders, Bor, & Morawska, 2006).

Finally, Sanders, Montgomery et al. (2000) demonstrated that a self-directed minimal intervention, delivered in the format of a television series with accompanying parent tip sheets for each episode, significantly reduced parental perceptions of child behaviour problems and increased self-reported maternal parenting competence, compared to a wait-list control.

There is also evidence that a BFI based on a self-regulatory model, delivered by trained telephone counsellors can have significant effects across a range of measures of family functioning (Morawska & Sanders, 2006a). The intervention led to reductions in parental reports of child behaviour problems, reductions in dysfunctional parenting for mothers, and increases in parenting efficacy and confidence for both parents. There were also reductions in parental conflict over parenting and maternal stress. These effects were evident not only in statistical terms, but also in clinical terms with a shift in the population norm towards lower levels of risk. Importantly, the effects were also maintained at follow-up, indicating that the intervention has not only immediate effects, but benefits continue over time.

Conclusions and Implications

The review presented here indicates that there is a paucity of research on methodologically sound, structured self-directed intervention approaches. At the same time, there is a growing need to increase access to efficacious parenting interventions for parents who find it difficult to access traditional services. Triple P is a behavioural family intervention with significant empirical support, and the studies reviewed here provide considerable evidence for the efficacy of self-directed versions of the program. Furthermore, the studies provide support for the importance of some therapist involvement in promoting clinically meaningful and reliable change in child behaviour and family functioning. It was a clear finding that therapist assistance in completing a self-directed parenting program led to greater positive change for families. While this therapist involvement was clearly important, it was very minimal and was focused on enhancing parents' self-regulatory skills. This emphasis on self-regulation enables parents to make successful, enduring changes for their children and families, and provides them with the structure and skills necessary to effectively problem-solve future difficulties.

There is growing evidence that self-directed behavioural family interventions based on a self-regulatory model provide a low-cost, effective intervention for families in the treatment of a range of behavioural difficulties across childhood. They allow parents who cannot access traditional services to access high quality evidence-based interventions. They also have the potential to form a valuable role in a multi-level intervention model, for example, when parents are on waiting lists for services. A therapist-assisted intervention socialises parents to the self-regulatory framework and key strategies that may be refined later in individual therapy if necessary, reducing demands on services. This review has provided evidence that therapist involvement is important and has considerable impact on the outcomes of behavioural family interventions across the spectrum of child development. While parents are able to

make changes on their own, their ability to implement strategies and maintain these in the longer term is affected by whether or not they are supported in doing so. Parents who receive therapist support make greater changes in their parenting and thus report increased levels of improvement in their child's behaviour. An area for future research is to consider the mechanisms involved in this effect. We posit that the self-regulatory framework utilised by therapists is key to better outcomes for families participating in a self-directed program. In addition, a motivational effect may also play a role in increasing parents' implementation of strategies. Clarification of the mechanisms involved would be important to specify the nature of therapist involvement, the training therapists need to conduct telephone-consultations and thus, the most efficient way of delivering support to families.

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